

FROM A MEDICAL TOURISM HOSPITAL TO A NATIONAL HEALTH SERVICE HOSPITAL IN EIGHT EASY YEARS! A CASE STUDY OF THE GOLDEN JUBILEE HOSPITAL IN GLASGOW, SCOTLAND

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Introduction

The aim of this paper is to outline how and why a private-sector, purpose-built hospital designed to attract overseas medical tourists to Glasgow in the early 1990s, did develop into a centre of medical excellence – but one wholly owned and managed by the National Health Service Scotland (NHS Scotland), as a Special Health Board Hospital and not as a centre for medical tourism.

In order to understand the background to this case study, it is important to recall that the provision of a National Health Service (NHS) is one of fundamental characteristics of the UK social welfare system. The NHS came about in the years following World War II with the British Government's aim being to provide a better, more caring and more inclusive society. It was one of five giants of the post-war Socialist policy, along with other ideals such as full employment, public housing, public transport and free education (Timmins, 1996).

In 1999 the responsibility for the provision of a public national health service (NHS) in Scotland was transferred from the UK Government to the newly devolved Scottish Executive (now the Scottish Government). Although the Scottish Government does not itself raise taxes, it is wholly responsible for the spending of public funds in Scotland on a wide range of functions such as education, transport, the judiciary, and the health care system. Because health care is now a devolved responsibility, local variations in its provision have arisen within the UK, and thrown into question the concept of equity (Woods, 2004), with Scotland developing its own health care system with its own distinctive characteristics and priorities. This policy change with the Scottish Executive responsible for health care in Scotland made it much easier for them to take the actions outlined below.

The case study hospital (Golden Jubilee Hospital and separately the Beardmore Hotel & Conference Centre) is located in Clydebanks on the western outskirts of Glasgow, formerly

one of the main areas for Scottish ship-building, but now one of the most deprived location in Scotland; there are high levels of unemployment, poor-quality housing, poor standards of health, and, most importantly, poor health-care facilities for its residents. The area is close to Glasgow International Airport (albeit on the other side of the River Clyde), and has an excellent 20/25 minute rail service to central Glasgow and good road links both to the city centre and to the Scottish motorway system. The site of the hospital is within the West Dunbartonshire Council area (West Dunbartonshire Council, 2009), formed in 1995 (just after the hospital opened) following the break-up of Strathclyde Region; the Council is now run by a coalition of the Scottish Nationalist Party and Scottish Labour Party.

The area surrounding the hospital, alongside the River Clyde, was at one time known for the quality of its ship-building – Clyde-Built is still a popular saying, indicating high quality – because the ships were built to a very high standard. In the 1920s and 1930s ship building started to decline, and this decline was only reversed as the Government started to prepare for War. During the 1939-45 War, Clydebank was very heavily bombed by the German air force and this resulted in many bomb-damaged sites, which added to the area's level of deprivation (Johnston, 1993, Beardmore Hotel & Conference Centre, 2009). In the period after the War there was some revival in ship-building and heavy manufacturing, but never to the same scale as before the War, and gradually the area along the River Clyde became derelict as industries declined.

The Main Players and the Rationale for a New Hospital

Although the local authority, Strathclyde Region, (until its demise in 1995) had responsibility for planning and development in the area, the Scottish Development Agency (SDA) – now Scottish Enterprise (SE) – was responsible for the economic development and regeneration in most of Scotland. Through its extensive funding powers, the SDA was able to give direct grants and loans to the private sector for projects to both carry out physical developments and create additional jobs at the Scotland level. This is important, because any jobs created through SDA projects had to be additional jobs, not jobs displaced from one area to another. Since its formation in 1975, the SDA tried to identify projects that would meet these criteria; examples include support for new electronics factories, call centres and business parks. It is important to note that – unlike its counterpart in the Highlands (the Highlands & Islands Development Board, now HIE) – the SDA did not have a social development role i.e. the impact of its development activities had to be justified on economic grounds and not just for social reasons.

Following the sharp increase in the price of oil in the 1980s, Middle East countries were awash with money and looking to invest in profitable projects. In order to manage such funds, a number of countries established separate development companies (quasi-independent of government) and they sought projects that would not only increase profits, but also provide a service to their citizens and present a positive image of the their country internationally. One such company was the Adu Dhabi Investment Company (ADIC), based in the United

Arab Emirates (UAE). The ADIC sought out overseas development projects which they could invest in, pending major projects in their own country to improve the quality of life of their citizens. Given the poor quality of their own health service, and their need to both build more facilities and to train additional staff in their own country, the ADIC decided that one method to improve the quality of life of its citizens was to develop/manage an already functioning hospital that could treat Abu Dhabi citizens in need of heart operations.

The Scottish Executive and the SDA were looking for high-profile signature projects to show how successful they were in managing the Scottish economy and the ADIC was seeking investment in health-care facilities, it was almost inevitable that they would find mutual ground for discussion. The ADIC wanted a quick return on its investment, but the planning and building processes in Scotland would take far too long to build a new hospital. The ADIC and the SDA, therefore, looked at what already existed in Scotland, which would match the requirements of both organisations.

In 1989/90 the SDA had previously assisted Heath Care International (HCI) to develop a private hospital in Scotland. The original site identified by the SDA for this hospital was only fifteen minutes from Glasgow Airport, had been a ship-building yard, but was now derelict. The SDA was restricted in the sites it could offer the HCI because its development grants could be used only in areas of high deprivation and those which had development-area status. These areas by their very nature tended to be deprived and rundown, and sited in some of the most impoverished urban areas in Scotland – those with high unemployment, poor housing and a poor quality of life for their residents. Clydebank matched all these criteria and it became the location of the HCI hospital. The site, however, presented difficulties because it had been used for ship-building and the manufacturing of asbestos, resulting in high site-clearance costs which were funded by the SDA, as was the costs for general site-preparation. These costs would have to be expended anyway, before any type of development could take place on the site, and this SDA policy of paying for site clearances was common in many of their development activities.

Eventually, in 1994, a new hospital, costing £185m, was developed on the site, providing space for 540 beds, but only 52 of which were ever made ready and used for patients, along with state-of-the-art operating facilities. Staff were employed directly by HCI, who paid wages higher than NHS Scotland; they were supported by specialist doctors mainly brought in from South Africa. Along with the 540 beds, the hospital had six operating theatres, MRI and CT scans, and space for expansion. What was unusual about this development, that alongside the hospital and actually sharing an entrance and facilities such as car parking, utilities, catering, 170-seat tiered auditorium and grounds was a 240-bedroom, four-star hotel, the Beardmore Hotel and Conference Centre.

It is difficult to understand just which markets HCI were hoping to attract, but the emphasis seemed to be on UK and European patients who had access to private health insurance. In 1994, three months after opening the HCI hospital, the company responsible for building the hospital went into receivership, because of the collapse of its parent company and not the

costs associated with the building and operation of the hospital and attached hotel. They were both bought as a package by the ADIC, with technical assistance from the SDA.

Initially, the SDA had provided financial assistance to the HCI hospital through its grant scheme to develop the site and was very keen to show that its capital funds were not wasted on another major project, as had happened elsewhere in Scotland. This seemed like a dream project because it created jobs, showed that Scotland and the Scottish Executive welcomed major developments, and that the Scottish Executive (through the SE/SDA) was willing to be flexible in meeting the ADIC's investment criteria, one of which was that the site had to be near a major airport, because its patients from the UAE would have to fly to Scotland.

It is important to note the Scottish Tourist Board (STB) was not involved in the development of the project, despite having at that time, the power to provide grants for the development of new tourism facilities and to provide advice on the tourism potential of large-scale projects. The STB were however approached for marketing advice, but HCI were informed (at that time) that the Middle East was not a priority market for Scotland (Wallace, 2009).

From 1994 to 2002, the hospital (still known as the HCI Hospital) operated as a private hospital controlled by the ADIC, to provide a service to wealthy Middle East clients, poorer citizens from the UAE whose treatment was funded their State, and private European patients.

Issues in the Management of the Hospital and Hotel

This hospital and hotel were managed by two completely separate management teams, both reporting directly to the ADIC board, through two separate limited companies. Although both facilities were of a very high quality in terms of their design, they faced a number of issues which contributed to their eventual closure and transfer in 2002 to NHS Scotland. These included:

- The hospital was regarded by the residents (or maybe more correctly the local Council) as 'not for them' as it did not meet their health needs (as local NHS patients) and this led to resentment in the area. The local Council (West Dunbartonshire) were very much against the hospital (Wallace, 2009), even although it provided jobs for local residents. A good example is that it took three years for the Council to provide directional road signs.
- The doctors were recruited mainly from South Africa, but did not live in Scotland; instead they flew in from South Africa and stayed only a few days, using the associated hotel accommodation.
- The UK private patients, who used the hospital, found that the main two providers of private health care in the UK threatened to blacklist their doctors, as they wanted to maintain, what was in effect, a cartel.

- The nurses were recruited locally and were paid wages substantially higher than comparable NHS rates; therefore the hospital was seen as taking trained staff away from the area's hospitals – and they could ill afford to lose skilled staff.
- The support staff (cleaners, receptionists, etc.,) were recruited locally, but did not have the necessary service skills, to provide a high-quality service.
- It is difficult to say if racism was an issue, but the hospital was known locally as the 'Arab Hospital', but this could just be local Glasgow humour.
- Initially the hotel found it challenging to attract non-medical tourism business, because many patients and their visitors used the hotel facilities, and 'ordinary' tourists did not like to see people in their dressing gowns and drips in the hotel's public areas.
- However, the hotel did prove to be attractive to non-medical tourists, and did make an operating profit (Wallace, 2009). It attracted a lot of UK group business from both the UK and overseas tourists. Closeness to the airport was not really an important factor, as many of the group tours used their own coaches, but it was important for individual leisure and business travellers, as the hotel provided a courtesy minibus service. The hotel was also well placed for rural attractions such as sightseeing at Loch Lomond and golfing in Ayrshire. Group tour operators liked the hotel because it was able to offer good rates for half board at a comfortable four star hotel. It also did well in attracting NHS conferences and given its closeness to Glasgow Airport, generated some non medical tourism conferences. It was also popular for wedding receptions (Tassell, 2009).
- There were no direct flights from the UAE to Scotland, which made it difficult and stressful for patients who had to fly to London or Manchester and then transfer, either to Glasgow airport or overland to the hospital. There was also an issue of patients using oxygen, when transferring through the London airports. However, today Emirates Airlines does fly direct from Dubai to Glasgow.
- Although most of the patients were from the Middle East, a number of UK and Scandinavian companies signed contracts with the HCI hospital to provide private medical services for their clients. NHS Scotland also used the services of the hospital to decrease NHS waiting times, especially towards the end of their financial year.
- It was a period of political change in Scotland, as the planning authority was being transferred from Strathclyde Region to West Dunbartonshire Council, so local political support for the hospital was weak.
- The investment company, ADIC, although owned by Adu Dhabi, was managed from London. The company had a policy of buying distressed assets, developing

them and running them as a going business, before selling them as a profitable asset. The hotel side of the business generated a profit, but the hospital did not.

As the volume of patients was never high enough to fill the 540 beds and in order to tackle some of the above issues, the hotel and the hospital undertook the following:

- They opened up their under-used facilities to NHS patients with heart problems and operations were performed by HCI surgeons at subsidised costs to the NHS. This was a difficult issue for the Scottish Executive which was controlled by the Labour party, because it went against the ethos of the NHS.
- The hospital agreed to contribute financially to the training of NHS nurses and undertook to provide clinical training at the hospital.
- The hospital and hotel agreed to give preference to local people in their applications for support jobs at the hospital and hotel.
- The hotel provided special accommodation rates for friends and relatives visiting local people.
- The hotel allowed local people to use the hotel's sports facilities.
- The hotel provided free use of its swimming pool to local schools at quiet times.
- They held open days and recruitment fairs aimed at local people.

The Closure Decision and Process

By 2002, some 2,500 NHS operations were being performed each year at the hospital – it had become a ‘de facto’ NHS hospital, albeit operated by the private sector. At the time of its closure in June 2002, still only 52 of the 540 beds were in use, and the hospital had incurred a cumulative debt of £82m (Scottish Parliament, 2002). While there has always been some criticism of the use of private hospitals for NHS patients, the Scottish Government has always been pragmatic about their use, responding to any criticism by saying “ask the patients being treated – are they critical?”

As well as treating Scottish NHS patients, the hospital was also treating patients from England, with claims by some Scottish politicians that because English patients were being treated, there were longer waiting times for Scottish patients. There was also concern that during the first three years of the Scottish Parliament (1999-2001) some 650 acute patient beds in Scotland had been lost and this was having a detrimental effect on waiting times for operations (BBC News, 2002a). In early 2002, the ADIC informally told the Scottish Executive that because of continuing losses it was planning to close the hospital and entered into detailed confidential discussions with the SDA/SE about the future of the HCI hospital. In June 2002, the Scottish Labour Government, elected in 1999 and still in its first term of office, announced that it had agreed to buy both the hospital and hotel for £37.5m (Scottish

Government 2002a). These were transferred to the NHS, along with some ten consultants, over 100 nurses and 170 support staff, as well as 90 staff who worked in the hotel (BBC, 2002b).

In order to estimate the full cost to the public of the takeover of the HCI hospital a number of costs need to be taken into account: including various direct grants, subsidies and building grants from the SDA and the Scottish Government, and the indirect costs to the NHS of the HCI hospital over the years. Although difficult to calculate accurately, it has been estimated that over ten years (1992-2002), total public expenditure to support the HCI hospital could be as high as £140m (Scottish Parliament, 2002). So the full cost to the public purse of buying the hospital was much higher than the initial direct costs of £37.5m in 2002.

For a number of reasons, including the politically sensitive issue of waiting times for some types of operations, the HCI hospital was to be given a national role, but was to be managed by a special Health Board, outside the normal NHS Scotland management structure. It was also to be the location of the NHS 24-hour advice call centre for the West of Scotland, and two new operating theatres would be developed at the hospital (Scottish Government, 2002b). The ADIC had failed to make the hospital a commercial success, and as stated in the Scottish Parliament by Malcolm Chisholm the then Minister for Health and Community Care (Scottish Parliament, 2002) the reasons for a take-over by the public sector were:

- Without a change in ownership the hospital would face closure.
- Its closure would be a major blow to the local community.
- It would put in jeopardy the jobs of many highly qualified health professionals.
- Because of increasing use by the NHS, its closure would remove the additional capacity gained by the NHS Scotland.
- The initial cost of £37.5m was perceived as good value for money, because it would cost £180m to build a new hospital, but this figure fails to take into account the £140m total public funds already spent (Scottish Parliament, 2002).

It was, in many ways, a pragmatic decision, but some people regarded it as an attack on the private sector. However, the NHS has always worked in partnership with the private sector, although at a low level and with little public acknowledgement.

The hospital was to be managed initially as a National Waiting Times Centre, with the prime aim of driving down waiting times for operations, which was a major issue in the early 2000s and one which generated a lot of negative press for the Scottish Executive (now Scottish Government). The hospital was to specialise in heart surgery, but also undertook knee and cataracts operations, as well as plastic surgery. It was also to provide a local diagnostic capacity; this was a tacit acknowledge that a NHS hospital had to provide some benefits and service to the local community, the lack of which had been a major criticism of the HCI hospital. In order to distance the hospital from its history as a private hospital, it was renamed the Golden Jubilee Hospital (BBC, 2002c). The aim of the renamed hospital was to increase

the number of NHS operations from 2,500 in 2002 to some 5,000 operations in 2003, and by 2008, about 28,000 operations per year were performed and all 540 beds were fully utilised (NHS Scotland, 2009).

Lessons Learned

- The hospital project was development driven, not market driven.
- The hospital tried to work in isolation from the culture of the local community – an island of excellence, in a sea of poverty (but it did employ local people).
- The question was posed: Is it right to recruit doctors from other countries, when their own country may have had a greater need for them.
- The difficulty of travel for patients from the Middle East was just too great to overcome (but it was convenient for UK and European patients).
- Even although the hospital was managed from London, it was seen by the ADIC as a tax write-off, with the owners living far away who never understood local issues and concerns.
- With the new Scottish Parliament still in its first term of office, the Scottish people expected action on a wide range of issues, and waiting times for surgery was a real concern, so buying the HCI hospital was not only fortuitous and pragmatic, but popular with the public.
- The people of Scotland got more than just 52 beds – they got a complete hospital and a four-star hotel.
- Politics at national and local levels were in a state of flux, both at the start of the operation of the hospital in 1994 with the new Local Authority structures, and in 2002 with its transfer to NHS Scotland with the new Scottish Parliament still in its first term, so political leadership was weak.

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